

MEDICAL EVALUATION FOR LEAD EXPOSURE

Name: _____ Social Security # _____

Date of birth: _____ Male _____ Female _____

Employer: _____

Employer's address: _____

Contact person: _____ Phone: _____

Address to send results to: _____

Phone: _____

Other employer(s) in past year: _____

Exposure History

Description of job _____

Job tasks in past year (check all that apply)

_____ Ironwork: cutting/burning/welding painted surfaces or lead-containing scrap metal

_____ Painting and lead paint abatement:

_____ containment: erecting/removing barriers or covers

_____ paint removal: _____ dry scraping _____ chemical removal _____ power sanding

_____ burning _____ abrasive blasting

_____ paint applications: brushing spraying

_____ cleanup: _____ sweeping _____ standard vacuum _____ HEPA vacuum

_____ Demolition

_____ Battery manufacturing /recycling

_____ Lead soldering _____ Lead smelting _____ Foundry work

_____ Radiator repair _____ Metal machining or grinding

_____ Wire or cable manufacture _____ Plastics manufacture

_____ Scrap metal recycling

Other possible exposures:

_____ Stained glass work _____ Pottery /ceramics _____ Folk medicines

_____ Firing range use or maintenance _____ Home renovation

Comments: _____

Protective measures

Respirator: (check those used) _____ Dust mask (disposable)
_____ Standard canister (negative-pressure) respirator
_____ Negative-pressure respirator, with HEPA filter
_____ Powered air-purifying respirator
_____ Supplied-air respirator

Have you been fitted for respirator and trained in its uses? _____ Yes _____ No
Have you had any difficulty wearing a respirator? _____ Yes _____ No
Do you: eat or drink in the work area? _____ Yes _____ No
 smoke in the work area? _____ Yes _____ No
 wash your hands before eating or smoking? _____ Yes _____ No
 wear your work clothes home? _____ Yes _____ No
Are facilities available for: eating in clean area? _____ Yes _____ No
 handwashing? _____ Yes _____ No
 showers? _____ Yes _____ No
Do you know of others you work with who have had high lead levels? _____ Yes _____ No
Have you had previous lead tests? _____ Yes _____ No
 Dates and results, if known: _____
Have you needed treatment for lead poisoning before, or removal from lead exposure because of a high level? _____ Yes _____ No

Current Symptoms

	Y	N	Comments
Weight loss	_____	_____	_____
Fatigue	_____	_____	_____
Poor sleep	_____	_____	_____
Metallic taste in mouth	_____	_____	_____
Loss of appetite	_____	_____	_____
Abdominal pain	_____	_____	_____
Nausea/vomiting	_____	_____	_____
Pain in teeth	_____	_____	_____
Constipation	_____	_____	_____
Irritability	_____	_____	_____
Headaches	_____	_____	_____
Memory problems	_____	_____	_____
Difficulty concentrating	_____	_____	_____
Hearing loss	_____	_____	_____
Numbness or tingling of hands or feet	_____	_____	_____
Joint pain	_____	_____	_____
Change in sex drive	_____	_____	_____
(Women) Change in menstrual periods	_____	_____	_____
Other	_____	_____	_____

Past Medical History

Have you ever had:

	Y	N	Comments
High blood pressure	_____	_____	_____
Kidney disease	_____	_____	_____
Anemia/low blood count	_____	_____	_____
Heart disease	_____	_____	_____
Asthma	_____	_____	_____
Emphysema	_____	_____	_____
Bronchitis	_____	_____	_____
Gout	_____	_____	_____
Arthritis	_____	_____	_____
Head injury	_____	_____	_____
Depression	_____	_____	_____
Difficulty conceiving a child	_____	_____	_____
A child with a birth defect or learning disability	_____	_____	_____
(Women) Miscarriage	_____	_____	_____

Social and Family History

Do any children live in your home? _____ Yes _____ No If yes, ages: _____

When was your home built (if known)? _____

Is there any lead paint in it? _____ Yes _____ No _____ Don't know

Do you smoke cigarettes? _____ Yes _____ No If yes, packs per day _____

Has alcohol ever been a problem for you? _____ Yes _____ No

When was your last drink? _____

Physical Examination

Height _____	Weight _____	BP _____	P _____
	Normal	Abnormal	Comment
HEENT			
(lead line optic disc)	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Abdomen	_____	_____	_____
Cranial nerves	_____	_____	_____
Motor strength			
(esp wrist extensors)	_____	_____	_____

Sensory			
(esp distal)	_____	_____	_____
Coordination	_____	_____	_____
Affect	_____	_____	_____
Orientation			
(place, person, time)	_____	_____	_____
Memory			
(object recall)	_____	_____	_____
Attention			
(serial 7s)	_____	_____	_____
Visual-spatial			
(design copying)	_____	_____	_____

Laboratory tests ordered:

Whole blood lead _____ ZPP _____
Hgb _____ Hct _____ MCV _____ Smear _____
BUN _____ Creat _____ U/A _____
Other _____

Optional tests:

Sperm analysis _____
Pregnancy test _____
Nerve conduction velocity _____

**Medical Evaluation for Lead Exposure
Results and Recommendations**
(copy to employer and employee)

Name: _____ Date of birth: _____

Date of evaluation: _____

Blood lead level: _____

Any condition detected which increases risk from exposure to lead? ____ Yes ____ No

Duty status:

_____ Continued duty

_____ Continued duty, but review of protective measures

_____ Medical removal from lead exposure, with wage protection*

_____ Medical removal and chelation therapy**

Respirator use:

_____ No restrictions on use

_____ Use with following accommodations: _____

_____ Not approved for respirator use

Follow-up:

_____ Follow-up medical evaluation in _____ weeks***

_____ Follow-up blood lead test in _____ weeks/months****

Evaluating M.D.

* **Medical removal:**

General industry: Blood lead level (confirmed) ≥ 60 mcg/dl; or average of ≥ 50 mcg/dl on last 3 tests or all tests over last 6 mos., (whichever is over a longer time period) unless last test < 40 mcg/dl

Construction: Blood lead level (confirmed) ≥ 50 mcg/dl
Continue until two consecutive levels ≤ 40 mcg/dl

** **Chelation:** only if significant signs or symptoms of toxicity

*** **Medical evaluation:** annually if blood lead level ≥ 40 mcg/dl, but medical removal not required unless employee reports signs or symptoms consistent with lead toxicity, desires advice about effects of lead exposure (e.g. reproductive effects), or has difficulty using respirator

**** **Next lead test:** Last blood lead level < 40 mcg/dl: 6 mos.
Last blood lead level ≥ 40 mcg/dl but not requiring medical removal: 2 mos.

Employees on medical removal: 1 month